GHI HealthPlan

2000

A Prepaid Comprehensive Medical Plan with a Point of Service Product

Serving:
Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment code:

801 Self Only

802 Self and Family

Visit the OPM website at http//www.opm.gov/insure
and
our website at http//www.ghi.com

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UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETRIEMENT AND INSURANCE SERVICE

Federal Employees
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Introduction

Group Health Incorporated

441 Ninth Avenue

New York, NY 10001

This brochure describes the benefits you can receive from Group Health Incorporated under its contract (CS1056) (GHI Health Plan) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communications more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to GHI Health Plan or GHI as "this Plan" throughout this brochure, even though in other legal documents you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **A Prepaid Comprehensive Medical Plan with a Point of Service Product.** This Plan is a Prepaid Comprehensive Medical Plan with a Point of Service Product. Turn to this section for a brief description of this Plan and how it works.
2 **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your requests for a service.
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **General exclusions — Things we don't cover.** Look here to see benefits that we will not provide.
7. **Limitations — Rules that affect your benefits.** This section describes limits that can affect your benefits.
8. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1 — A Prepaid Comprehensive Medical Plan with a Point of Service Product

This Plan is a prepaid medical plan that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange your care and you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

Because the Plan emphasizes care through participating providers and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a more comprehensive range of benefits than many insurance plans. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Section 2 — How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

1. Under the Medical and Surgical section the 15 visit per calendar year limitation for chiropractic services has been eliminated.
2. Under the Mental Conditions benefits section, the 30 visit outpatient care limitation and the 60 days inpatient care limitation have been eliminated.
3. Under the Prescription Drug benefits section, the following benefits changes are made:
   a. The Retail Drug copays have been increased from $10 for a name brand drug and $5 for a generic drug to $20 for a name brand drug, which is not listed on the preferred prescription drug formulary, $15 for a brand name drug, when it is listed on the preferred prescription drug formulary, and $5 for a generic drug.
   b. The Maintenance Drug copays have been increased from $10 for a name brand drug and $5 for a generic drug to $20 for a name brand drug and $10 for a generic drug.
   c. A Mandatory Mail Program for Maintenance Medication has been implemented. You can get your original prescription filled, plus two refills of the original prescription at a participating pharmacy. After two refills, all fills must be received through the mail service prescription benefits.

Section 3 — How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services as defined below:

Copayment — A set dollar amount for services rendered by a participating provider.

Coinsurance — A set percentage of GHI's scheduled allowance for services rendered by a non-participating provider (An enrollee is responsible for charges in excess of the fee schedule).

Deductible — An annual fixed dollar amount for nursing appliances, oxygen and equipment benefits that must be met before benefits are payable.

In the event you receive any of the covered services described below rendered by a non-participating provider and incur out-of-pocket expenses in a calendar year of more than a $5,000 per person catastrophic deductible, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges, as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services.

Covered catastrophic services. Covered services under catastrophic coverage include:

(1) Surgery
(2) Administration of anesthesia
(3) Chemotherapy and radiation therapy
(4) Covered in-hospital services and diagnostic services
(5) Maternity

Non-catastrophic services. The following services are not covered under catastrophic coverage:

(1) Home and office visits and related diagnostic services
(2) Nursing, Appliances, Oxygen and Equipment
(3) Dental services
(4) Vision services
(5) Prescription drugs

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or whenever you use any non-participating provider. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or GHI can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

A **"provider"** as used in this brochure includes any duly-licensed doctor, dentist, podiatrist, qualified clinical psychologist, optometrist, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly licensed, registered or certified practitioner or privately operated facility permitted to perform or render care or service described in this brochure.

A medical/surgical provider who participates has agreed to limit fees to the GHI allowance and to await payment from GHI. Such a provider must be notified by the subscriber before service is rendered that GHI is the insurer.

A medical/surgical provider who does not participate has no agreement with GHI and does not have to accept GHI payments as payment in full. **Only 50% of GHI's scheduled allowance will be paid to you if you use the services of a non-participating medical/surgical provider.** Services of non-participating diagnostic laboratory facilities, x-ray facilities, and anesthesia are covered at the plan's full medical/surgical fee schedule. Payment may be less than actual charges. In addition, you can not transfer your right to collect payment from GHI to another person, corporation or other organization. Any assignment by you will be void.

If you are newly enrolling in this Plan, you will be given a GHI medical/surgical/hospital identification card, and a GHI prescription drug card. The medical/surgical/hospital card is to be used for all services except drug benefits. The medical/surgical/hospital card contains telephone numbers, which you are required to call before non-emergency hospital confinement or surgery of the type referred to on page 11.

What do I do if I need to go to the hospital?

If you need to be hospitalized, your physician or specialist will make the necessary hospital arrangements and supervise your care.

Section 3 — How to get benefits *continued*

What do I do if I'm in the hospital when I join this Plan?

First, call our Customer Service Department at 212/501-4444. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your plan requires precertification for certain services such as high-tech nursing, infusion therapy, mental health and substance abuse benefits, non-emergency hospital admissions, and all inpatient hospital admissions for maternity care and skilled nursing facilities. In addition, although a specific service may be listed as a benefit, it will not be covered for you unless the Plan itself determines it is medically necessary to prevent, diagnose or treat your illness or condition.

How do you decide if a service is experimental or investigational?

The Plan considers factors which it determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature, or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device, or medical treatment. The Plan also considers Federal and other government agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.

Section 4 — What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious life threatening condition and you haven't responded to my request for service?

Call us at 212/615-4662 and we will expedite our review.

Section 4 — What to do if we deny your claim or request for service

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment, too. Alternatively, you can call OPM's Health Benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Serious or life threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5 — Benefits: Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by doctors and other providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays by **Participating Providers**. Within the Service Area, house calls will be provided if in the judgment of the Plan such care is necessary and appropriate; **you pay** a $10 house call copay for a participating doctor's visit, and nothing for visits by nurses. **Participating doctors** also provide all necessary medical or surgical care in a hospital **at no additional cost to you.**

Section 5 — Benefits: Medical and Surgical Benefits *continued*

The following services are included:

- Preventive care, including well-baby care (no copay applies) and periodic check-ups.
- Mammograms are covered as follows: For women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (The cost of the immunizing agent is covered for children to age 22).
- Consultations by specialists, upon referral from attending doctors (one inpatient per confinement and one outpatient per illness).
- Diagnostic procedures, such as laboratory tests and X-rays.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a participating doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Routine nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services.
- Chiropractic services.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, which includes the cost of the test and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Non-experimental transplants, including cornea, human heart, heart/lung, lung, pancreas, kidney and liver transplants. Allogenic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic leukemia or non-lymphatic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Additionally, autologous bone marrow transplants (autologous stem and peripheral stem cell support) and high dose chemotherapy for the following conditions: Breast cancer, multiple myeloma, and epithelia ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis.
- Chemotherapy and radiation therapy.
- Inhalation therapy.
- Surgical treatment of morbid obesity.
- High-tech nursing and infusion therapy through GHI's participating provider network for services of I.V. infusion therapy, parenteral and enteral therapy, and other home I.V. therapy. Participating providers must be used for these services. Contact GHI at 212/615-4662 prior to receiving services to ensure coverage.
- Intermittent home nursing service — The Plan pays full charges when billed by a home nursing service for services of a Registered Nurse or, if not available, a Licensed Practical Nurse, provided that the service is authorized and supervised by a doctor, subject to the same limitations as those imposed for other providers rendering the same type of covered service. The Plan covers only intermittent visits, generally for less than two (2) hours per day.

Plan provides payment in full for medical-surgical benefits shown above by Participating Providers. Only 50% of the Plan's fee schedule will be paid, unless otherwise stated, for services of a non-participating medical-surgical provider. Failure to precertify nonemergency hospital confinements and certain surgical procedures will result in benefit reductions. (See Page 11.)

Section 5 — Benefits: Medical and Surgical Benefits *continued*

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, the removal of impacted teeth, the treatment of fractures and the excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Podiatric services, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails, are limited to 4 visits per calendar year.

Diagnosis and treatment of infertility is covered (as well as associated prescription drugs which are covered under the Prescription Drug Benefits). The cost of donor sperm is not covered. **Other assistive reproductive technology (ART) procedures** that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures, such as in vitro fertilization (limited to three transfers per lifetime) and embryo transfer and artificial insemination, are covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided; you pay a $10 copay per session.

Reconstructive surgery will be provided to correct a condition resulting from a functional defector from an injury or surgery, which has resulted from accidental injury or from surgery if the accident or injury has produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Multiple surgery — The allowances for multiple surgery when one incision is made are limited to the highest payment for a single procedure involved. When two or more surgical procedures requiring more than one incision are performed at the same time, the allowance is limited to the highest payment, plus one-half of each of the lesser payments.

Short-term rehabilitative therapy (physical, speech and occupational) in a general hospital or approved facility is provided on an inpatient or outpatient basis, for up to 60 visits per condition if significant improvement can be expected within two months; you pay a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Nursing, appliances, oxygen and equipment: For nursing services, you pay the annual deductible of $150 per individual or family. When you use a GHI Participating Provider for nursing services, no further out-of-pocket expenses would be incurred by you. When you use a non-participating provider, you are responsible for 50% of the Plan's fee schedule after you have satisfied your deductible, plus any charges that exceed the fee schedule. For appliances, oxygen and equipment, you pay the annual deductible of $100 per individual or family. When you use a GHI Participating Provider for appliances, oxygen and equipment, you are responsible for 20% of the Plan's fee schedule after you have satisfied your deductible. When you use a non-participating provider, you are responsible for 50% of the Plan's fee schedule after you have satisfied your deductible, plus any charges that exceed the fee schedule. There is a maximum Plan payment for these combined benefits of $25,000 per member per calendar year. **The following services are covered when prescribed by a medical doctor:**

- Active private duty nursing service rendered at home or in the hospital by a registered nurse (R.N.) or, when an R.N. is not available, by a licensed practical nurse (L.P.N.).
- Durable medical equipment (as defined by Medicare), such as wheelchairs, hospital beds, and oxygen for home use.
- Artificial eyes, limbs, lenses following cataract removal or prosthetic appliances to replace internal body organs.
- Breast prostheses and surgical bras (in connection with covered breast reconstructive surgery).
- Orthopedic devices, such as braces.
- Ostomy supplies.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel, or governmental licensing.
- Elective cosmetic surgery.
- Cost of donor sperm.
- Reversal of voluntary, surgically-induced sterility.
- Custodial care.

Section 5 — Benefits: Medical and Surgical Benefits *continued*

- Hearing aids.
- Homemaker services.
- Services furnished or billed for by an extended care facility, nursing home, or other non-covered facility.
- Blood and blood derivatives received on an outpatient basis (no charge if replacement is arranged by member).
- Air purifying devices.
- Long-term rehabilitative therapy.
- Orthotic devices for the feet.
- Stand-by services.
- Alarm and Alert services.

TO RECEIVE FULL BENEFITS CARE MUST BE OBTAINED FROM PLAN DOCTORS

Section 5 — Benefits: Hospital/Home Health Care

What is covered

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a doctor. You pay nothing for services billed by the admitting hospital. All necessary services are covered, including:

- Semiprivate room accommodations; when medically necessary, the doctor may prescribe private accommodations.
- Specialized care units, such as intensive care or cardiac care units.
- Facility charges for the following outpatient services:

  Ambulatory surgery.

  Pre-admission testing (Surgery must actually take place within 7 days after tests are performed).

  Renal dialysis.

  Mammography and pap smear screenings.

  Chemotherapy and radiation therapy.

  Emergency room treatment ($25 co-payment per emergency room visit).

  Ambulatory laboratory test and diagnostic X-rays,when referred and rendered,

  subject to a $25 deductible per referral.

Precertification of hospital confinement

Nonemergency admissions must be precertified prior to admission. All inpatient hospital admissions for maternity care and skilled nursing facility must be approved by the Plan whether or not the case is an emergency. Maternity admissions should be precertified no later than the second trimester. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). Responsibility for informing GHI rests with you, the subscriber. Urge your doctor to contact GHI as soon as possible. You or your doctor must call the Plan at 212/615-4662 in New York City or 1/800/223-9870 outside New York City. If precertification is not obtained, benefits will be reduced by $125 per day to a maximum of $250.

Large case management

The Plan provides a large case management program which seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when GHI is notified that an enrollee or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers assess individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling.

If it is determined that involvement of a Case Manager would be both care- and cost-effective, GHI will obtain the necessary authorization from the patient to proceed. Throughout the process, GHI will maintain strict confidentiality.

Section 5 — Benefits: Hospital/Home Health Care Benefits *continued*

Skilled nursing care facility

Within 14 days following discharge from a hospital after a covered admission of at least 3 days, the Plan will cover up to 30 days per calendar year of full-time skilled nursing care for confinements in a participating skilled nursing facility, which are in lieu of hospitalization. Participating Providers must be used for these services. Contact GHI at 212/615-4662 prior to receiving services to ensure coverage. The following services are covered:

- Bed, board and general nursing services in a semi-private room.
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility as governed by Medicare guidelines.

Your condition must require skilled nursing that can only be provided in a skilled nursing facility, and the skilled care must be based on a doctor's order.

Home health care benefits

Following discharge from a hospital after a covered admission, benefits are provided for the covered home health care service stated below if (1) services rendered are billed by a certified home health agency which has an agreement with GHI to provide home health care services "and" (2) the subscriber remains under the care of a medical doctor "and" (3) the services are provided according to a plan of treatment approved by the attending medical doctor "and" (4) medical evidence substantiates that the subscriber would have required further inpatient care had the home health care not been available "and" (5) the home health care begins within 5 days after the discharge from the hospital. Participating Providers must be used for these services. Contact GHI at 212/615-4662 to pre-certify and ensure coverage.

What is covered

- Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse.
- Physical therapy.
- Respiration or inhalation therapy.
- Prescription drugs.
- Medical supplies which serve a specific therapeutic or diagnostic purpose.
- Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized.

What is not covered

- Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter.
- Services and supplies related to normal maternity care.
- Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility.
- Services and supplies provided when the subscriber would not have required continued inpatient care.
- Services and supplies provided by a non-participating facility.
- High-tech nursing and infusion therapy.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. An eligible hospice organization is one which has an agreement with GHI and/or is recognized as a hospice by Medicare.

Ambulance services

The Plan pays up to $100 for an ambulance service for each trip to or from a hospital in connection with the types of services covered by the contract. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. You pay all charges above Plan payment.

Organ transplants

Hospital benefits for the organ transplant procedures described on Page 9 will apply only to covered patients and will include:

- All medically necessary inpatient and outpatient hospital charges of the recipient patient.
- All medically necessary medical, surgical and hospital costs of the donor patient, when the recipient is covered by the Plan, related to the donation of the organ used in the transplant procedure, such as the surgical procedure necessary to procure the organ, storage expenses, and organ transportation costs, up to a maximum of $10,000 per transplant.
- Travel expenses up to a maximum of $150 per person per day and $10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center, including food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place.
- The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to $1,000,000 per recipient for each type of covered transplant.

Section 5 — Benefits: Hospital/Home Health Care Benefits *continued*

Limited benefits inpatient dental procedures

Hospitalization for certain dental procedures is covered when a doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 14 for nonmedical Substance Abuse Benefits.

What is not covered

To avoid possible reduction in benefits, you must precertify all non-emergency hospital confinements. See Page 11.

- Personal comfort items, such as telephone and television.
- Custodial care, rest cures, domiciliary or convalescent care.
- Extended care.
- Blood and blood derivatives received on an outpatient basis (no charge if replacement is arranged by member).
- Long-term rehabilitation.
- Air ambulance and Ambulette service.
- Transplants not listed as covered.

Section 5 — Benefits: Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. It is your responsibility to ensure that the Plan has been timely notified.

Benefits within the service area

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Plan pays . . .

Emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay. . .

$25 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan. You also pay charges which exceed the Plan's emergency fee schedule. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Plan pays. . .

Full emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers; 80% of charges from a non-participating hospital.

You pay. . .

$25 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities and nothing for emergency services billed for by a doctor, except charges which exceed the Plan's emergency fee schedule, for services which are covered benefits of this Plan. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 12).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

If the medical/surgical care received from non-participating providers is not due to a medical emergency as defined above, the Plan will pay 50% of its fee schedule. Follow-up care after an emergency is covered in full only if received from participating providers.

Section 5 — Benefits: Mental Conditions Benefits

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders. Only services rendered by a Participating Provider are covered. You must pre-certify before you receive benefits by calling GHI at 1-800/692-7311.

- Diagnostic evaluation.
- Psychological testing.
- Psychiatric treatment (including individual and group therapy).
- Hospitalization (including inpatient professional services).
- Life Management Services - telephone consultation services for a) finance & credit, b) childcare, c) eldercare, d) legal problem, e) organizing life's affairs, f) taxes, and pre-retirement questions. (These services are not subject to the outpatient and inpatient limits).

Outpatient care

You are covered for outpatient care, subject to a $10 copay when you use a Participating Provider, when the diagnosis is listed in the "Diagnostic and Statistical Manual, Fourth Edition" ("DSM IV Revised") as a mental disorder and there is impairment in one or more important areas of functioning.

Inpatient care

You are covered in a participating general hospital or participating private facility. All inpatient admissions for mental conditions must be precertified by the Plan prior to admission. You must contact GHI at 1-800-692-7311 for precertification prior to admission and to determine the hospital's current eligibility status or facility's current participating status in order to ensure coverage. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). You pay nothing for medically necessary covered services.

What is not covered

- Care for psychiatric conditions that in the professional judgment of the Plan are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.
- Benefits are payable only when personally rendered by doctors who confine their practices to psychiatry, by a licensed and registered psychologist, or a certified and qualified psychiatric social worker.
- The following diagnoses are not payable in that they are defined in the "DSM IV, Revised" Manual as conditions not attributable to a mental disorder: malingering; borderline intellectual functioning; adult antisocial behavior; childhood or adolescent antisocial behavior; academic problem; occupational problem; uncomplicated bereavement; noncompliance with medical treatment; phase of life problem or other life circumstance problem; marital problem; parent-child problem.
- Facility charges of a non-participating general hospital or facility.
- Treatment by a non-participating provider.

Section 5 — Benefits: Substance Abuse Benefits

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment. Only services rendered by a Participating Provider are covered. You must pre-certify before you receive benefits by calling GHI at 1-800-692-7311.

Outpatient care

Up to 60 outpatient visits to the outpatient department of a participating hospital or certified approved participating facility for follow-up care and counseling; You pay nothing for each covered visit — all charges thereafter.

Inpatient care

Up to a maximum of 30 days per calendar year for substance abuse rehabilitation (intermediate care) programs in a participating general hospital or Participating Private Facility. All inpatient admissions for substance abuse must be precertified by the Plan prior to admission. You must contact GHI at 1-800-692-7311 for precertification prior to admission and to determine the hospital's current eligibility status or facility's current participation status in order to ensure coverage. In case of emergency, GHI should be notified within 48 hours (72 hours if confined on a weekend). You pay nothing for medically necessary covered services during the benefit period — all charges thereafter.

What is not covered

- Treatment that is not authorized by a doctor.
- Facility charges of a non-participating general hospital or facility.
- Treatment by a non-participating provider.

Section 5 — Benefits: Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a doctor and obtained at a pharmacy that participates under the program through PAID Prescriptions, Inc. Coordinated Care Network III will be dispensed for up to a 31-day supply. Drugs are prescribed by doctors and dispensed in accordance with the Plan's drug formulary. You pay a $5 copay for a generic drug, a $15 copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a $20 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.

Covered medications and accessories include:

- Drugs for which a prescription is required by law.
- FDA approved prescription drugs and devices for birth control.
- Fertility Drugs.
- Drugs to treat sexual dysfunction (Viagra is limited to six tablets per every thirty-one days).
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape.
- Disposable needles and syringes needed for injection of covered prescribed medication.
- Allergy serum.
- Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply).
- Intravenous fluids and medications for home use through GHI's Participating Provider network for home infusion therapy.

In addition to covered prescription drugs, you are covered for enteral formulas if each of the criteria set forth below are met:

- A covered Provider has given a written order and/or a prescription.
- It must be proven effective as a disease-specific treatment regimen for persons who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death.

You are also covered for these modified food products that are low in protein or contain modified protein if each of the criteria set forth below are met:

- An authorized Provider has given a written order and/or a prescription.
- It must be for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

You are covered for these modified food products up to a maximum of $2,500 per calendar year or any continuous twelve (12) month period. You must submit your written order or prescription and store receipt for modified food products along with a completed claim form to: GHI, P.O. Box 2868, New York, New York 10116-2868

Mandatory Mail: Your prescription coverage also includes a mandatory mail program. All maintenance medications must be sent to Merck Medco Rx Services. Two refills per prescription will be allowed at any local "preferred" TelePAID pharmacy. When a new maintenance medication is prescribed the patient should request 2 prescriptions. The initial for a 31 day supply to be filled at a retail pharmacy, and the second, for up to a 90 day supply, to be submitted, using the enclosed envelope, to Merck Medco Rx Services. For all existing maintenance medications at a retail pharmacy, the patient is required to obtain a new prescription, for up to a 90 day supply, to be sent to Merck Medco Rx Services.

Maintenance Drug Program — The maintenance drug program permits long-term prescriptions to be filled for up to a 90-day supply. **You pay** a $10 copay for a generic drug, a $20 copay per prescription unit for a name brand.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available.
- Drugs obtained at a non-participating pharmacy except for emergencies.
- Vitamins and nutritional substances that can be purchased without a prescription.
- Medical supplies such as dressings and antiseptics.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.

Section 5 — Benefits: Other Benefits

Dental Care

What is covered

This Plan provides the following program of dental coverage. The emphasis is on prevention, with preventive and diagnostic dental services covered with no copayments through Participating Plan Dentists. Services by non-participating dentists are covered in accordance with the fees listed below:

This Plan provides the following program of dental coverage:

	Plan Pays
• Examinations - maximum 2 per calendar year	$10.00 each
• Prophylaxes - under 12 years (maximum 2 per calendar year)	$ 7.00 each
• Prophylaxes - over 12 years (maximum 2 per calendar year)	$10.00 each
• Emergency visits for relief of pain (1 per calendar year)	$10.00
• X-rays	
Full-mouth series, 1 every 3 years	$20.00
Bitewings, (4 per calendar year)	$ 2.50 each
• Space maintainers	$65.00 maximum
• Fluoride treatments - dependent children to age 22	$ 5.00

Accidental injury benefits

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury caused by external means and services must be completed within one year. It must occur while the member is covered under the FEHB Program. **You pay** the difference between the fee schedule and the actual charges.

What is not covered

- Therapeutic service.
- Other dental services not shown as covered.
- Charges which exceed the Plan's fee schedule.

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides certain vision care benefits. You pay nothing for covered benefits provided by participating opticians, optometrists and vision centers. Services by non-participating providers are paid in accordance with the Plan's fee schedule.

- Examination of the eyes to determine if glasses are required: once each calendar year.
- One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year.
- One pair of basic frames from available styles: one every two years.
- Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment).
- Replacement of broken lenses with lenses of the same prescription and material originally supplied.

What is not covered

- Frames at any time unless lenses are also provided.
- Replacement or repair of frames.
- Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes.
- Charges in excess of the maximum GHI allowance.

Catastrophic medical coverage

In the event you receive any of the covered services described below rendered by a non-participating provider and incur out-of-pocket expenses in a calendar year of more than a $5,000 per person catastrophic deductible, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges, as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services.

What is covered

Covered catastrophic services. Covered services under catastrophic coverage include:

(1) Surgery
(2) Administration of Anesthesia
(3) Chemotherapy and radiation therapy
(4) Covered in-hospital services and diagnostic services
(5) Maternity

What is not covered

Non-catastrophic services. The following services are not covered under catastrophic coverage:

(1) Home and office visits and related diagnostic services
(2) Nursing, Appliances, Oxygen and Equipment
(3) Dental services
(4) Vision services
(5) Prescription drugs

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program but are made available by GHI to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Dental services are available at reduced fees.

If you should require additional dental services, a GHI dental provider participating in the benefit offer, will provide these services at reduced fees. All reduced fees for dental services must be paid directly to the participating dental provider. You must verify that your provider is still participating in the program.

Dental services available in the reduced fee program include:

	DOWNSTATE*	UPSTATE**
DIAGNOSTIC	**You Pay**	**You Pay**
RESTORATIVE (Fillings)		
Resin (anterior) 1 surface	$52.00	$38.00
Resin (anterior) 2 surface	$69.00	$48.00
Resin (anterior) 3 surface	$86.00	$59.00
PROSTHODONTICS REMOVAL		
Complete denture (upper or lower)	$660.00	$441.00
Partial denture resin base (Bilateral Chrome)	$664.00	$453.00
Add tooth to existing partial	$65.00	$54.00
Add clasp to existing partial	$73.00	$59.00
PROSTHODONTICS FIXED		
Bridge pontic (cast mental)	$520.00	$409.00
Porcelain fused to metal	$510.00	$399.00
Full cast crown with porcelain veneer backing	$552.00	$432.00
ORAL SURGERY		
Extraction (completely covered by bone)	$269.00	$210.00
Soft tissue extraction	$172.00	$118.00
PERIODONTICS (Gum Treatment)		
Gingivectomy (per quadrant)	$200.00	$169.00
Osseous Surgery (per quadrant)	$470.00	$382.00
ENDODONTICS (Root Canal)		
Therapeutic pulpotomy	$82.00	$50.00
Root canals (3 canals)	$466.00	$466.00
Apicoectomy (first root)	$306.00	$314.00
ORTHODONTICS (Braces)		
Diagnostic and planning fee	$912.00	$686.00
Active Treatment Maximum	$2,220.00	$1,680.00

Benefits on this page are not part of the FEHB contract.

** Downstate includes New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Putnam, Orange, Rockland and Westchester Counties and New Jersey*
*** Upstate includes Eastern, Central, and Western New York Counties.*

Section 6. General exclusions — Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan itself determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational. Subscribers are not covered for expenses for expenses that GHI determines to be related to:
  - (a) experimental treatment; or
  - (b) investigational treatment; or
  - (c) clinical trials.

Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.

Investigational treatment includes, but is not limited to services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.

Clinical trials include, but are not limited to controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involve the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test treatment. Clinical trials include Phase I, Phase II and Phase III Studies. Clinical trials also include randomized trials or studies.

- Procedures, services, drugs and supplies related to sex transformations.
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.
- Experimental or investigational procedures, treatments, drugs or devices;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations — Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to the Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6855.

Section 7. Limitations — Rules that affect your benefits *continued*

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contract us for our subrogation procedures.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide;
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in a amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

Section 8. — FEHB facts

You have a right to information about your Plan.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Subscriber Relations Department at 212/501-4GHI (4444), or 212/721-4962 (Hearing impaired — TDD) or you may write to them at Post Office Box 1701, New York, NY 10023-9476 or contact the GHI office nearest you. You may also contact the Plan at its website at http://www.ghi.com. If you have a question concerning a hospital claim, contact GHI's Hospital Service Department at 212/615-0500.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a Guide to Federal Employees Health Benefits Plans, brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;

Section 8. — FEHB facts *continued*

- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

When you retire you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

What types of coverage are available for me and my family?

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before, to 60 days after, you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in the Plan ends?

You will receive an additional 31 days of coverage, for no additional premium when:

- Your enrollment ends, unless you cancel your enrollment, or
- You or a family member is no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

When you lose benefits *continued*

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC)

If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC

- You can pick a new plan.
- If you leave Federal service, you can receive TCC for up to 18 months after you separate.
- If you no longer qualify as a family member, you can receive TCC for up to 36 months.
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice; whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

What is TCC? *continued*

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation there may be an error.
- If the provider does not resolve the matter, call us at 888/456-3728 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

U.S. Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E. Street, NW, Room 6400

Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for GHI Health Plan — 2000

Do not rely on this chart alone. *All benefits are provided in full unless otherwise indicated, subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).*

NOTE: If you use a medical-surgical provider who does not participate, you will receive only 50% of the GHI fee schedule.

BENEFITS		PLAN PAYS/PROVIDES	PAGE
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	11
	Extended Care	All necessary services for up to 30 days per year. **You pay** nothing	12
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing	14
	Substance Abuse	Up to 30 days of substance abuse treatment per year. **You pay** nothing	14
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit or house call by a doctor (copay does not apply to well-baby care)	14
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	12
	Mental Conditions	Diagnosis and treatment of active psychiatric conditions visits for outpatient treatment per year. **You pay** a $10 copay per visit	14
	Substance Abuse	Up to 60 visits per year. **You pay** nothing	14
Emergency care		Services and supplies required because of a medical emergency (80% of charges from a non-participating hospital outside the Service Area). **You pay** a $25 per emergency room visit and charges in excess of the Plan's emergency fee schedule and charges for services which are not covered benefits of this Plan and (20% of charges from a non-participating hospital outside the Service Area)	13
Prescription drugs		Drugs prescribed by a doctor and obtained at a participating pharmacy. **You pay** a $5 copay for generic drugs, a $15 copay per prescription unit or refill for name brand drugs listed on the preferred prescriptions drug formulary and a $20 copay per prescription unit or refill for a name brand drug not listed on the preferred presciption drug formulary. For mail-order maintenance drugs, **you pay** a $10 copay for generics, a $20 copay for name brand	15
	Mandatory Mail	Your prescription coverage also includes a mandatory mail program. All maintenance medications must be sent to Merck Medco Rx Services. Two refills per prescription will be allowed at any local "preferred" TelePAID pharmacy	15
Dental care		Accidental injury benefit. **You pay** in excess of fee schedule. Preventive and diagnostic dental care	16
Vision care		One refraction annually. Lenses (annually) and frames (every two years). **You pay** nothing to participating vision centers	16
Out-of-pocket limit		Your out-of-pocket expenses for benefits covered under this plan are limited to the stated payments which are required for a few benefits and/or to the difference between the Plan's payment for non-participating providers and the provider's charges	6-7

2000 Rate Information for GHI Health Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but are not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Services Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium Biweekly		Non-Postal Premium Monthly		Postal Premium A Biweekly		Postal Premium B Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**	**USPS Share**	**Your Share**
Self Only	**801**	**$78.65**	**$26.21**	**$170.40**	**$56.80**	**$93.06**	**$11.80**	**$93.06**	**$11.80**
Self and Family	**802**	**$175.97**	**$86.18**	**$381.27**	**$186.72**	**$207.74**	**$54.41**	**$201.02**	**$61.13**